Public Employees Health Program

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Customer Service: (801) 366-7555 / Toll Free (800) 765-7347

Local Governments
Medical and Dental Enrollment and Change Form

Important Note:
Changes made on this form will affect your medical and dental coverages only. If you need to make changes to other coverages, please complete the appropriate forms for those plans.

Section A
Employee and Coverage Information

☐ New Enrollment ☐ Change Requested (Please specify type): _____

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS	GENDER
HOME ADDRESS	CITY / STATE / ZIP	HOME PHONE	☐ Single ☐ Married	☐ Male ☐ Female
EMPLOYER		WORK PHONE	HIRE DATE (mm/dd/yy)	

Group Medical (check one)[1]

- ☐ Preferred Medical Care
  - ☐ Option 1
  - ☐ Option 2
  - ☐ Option 3
- ☐ Summit Care *
  - ☐ Option 1
  - ☐ Option 2
- ☐ Advantage Care *
  - ☐ Option 1
  - ☐ Option 2
- ☐ Comp Care 1*
- ☐ Comp Care 2*
- ☐ No medical coverage at this time

COVERAGE TYPE (check one)

- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

Group Dental (check one)

- ☐ Preferred Choice Dental Care
- ☐ Traditional Dental
- ☐ No dental coverage at this time

COVERAGE TYPE (check one)

- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

1. If you have had previous health coverage within the last 9 months, please attach a Certificate of Creditable Coverage from your former insurance company.
* These plans are offered in specific geographic areas. Please check the specific plan information before enrolling.

Section B
Dependent Information

ADDITIONS

Complete the table below listing your eligible dependents. If adding a new spouse, please include date of marriage. If dependents are stepchildren, natural children not living with both parents, or classified as other relationship please provide supporting documentation, i.e. divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation please explain in Section D.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS TO BE COVERED (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE Month	Day	Year	DEPENDENT SOCIAL SECURITY NO.	Does the dependent have other Medical/Dental Insurance?	
CODE KEY	**S**			☐M ☐F					☐ Yes ☐ No	**Important:** If any dependent has other coverage Section C must be completed.
S - Legal Spouse				☐M ☐F					☐ Yes ☐ No	
C -Child Natural / Adopted				☐M ☐F					☐ Yes ☐ No	
				☐M ☐F					☐ Yes ☐ No	
SC - Stepchild				☐M ☐F					☐ Yes ☐ No	
O - Other (Describe in Section D)				☐M ☐F					☐ Yes ☐ No	
				☐M ☐F					☐ Yes ☐ No	

CUSTODY OF CHILDREN

*If dependents listed above are not living with **BOTH** natural parents, please complete the following:*

Who has physical custody of the natural children?
☐ Mother ☐ Father

Please provide names and birth dates of both natural parents.
Mother: _____ (Name / Birth Date) Father: _____ (Name / Birth Date)

Who has physical custody of the stepchildren?
☐ Mother ☐ Father

Provide names and birth dates of natural parents of stepchildren.
Mother: _____ (Name / Birth Date) Father: _____ (Name / Birth Date)

Signature required, see Section E on reverse side.

(HR Use Only)
Effective Date: _____ HR Approval: _____

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Employee Name: _____ Social Security Number: _____

REMOVALS

Fill out the table below if you are terminating coverage for dependents who are no longer eligible. ***If termination is a result of a divorce and children are involved, please provide a copy of divorce decree.***

RELATIONSHIP TO EMPLOYEE		DEPENDENTS TO NO LONGER BE COVERED (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (i.e. marriage, divorce, death, age of 26, etc.)	APPLICABLE DATE*		
					Month	Day	Year
CODE KEY S - Spouse C - Natural / Adopted SC - Stepchild O - Other (Describe in Section D)							

*Applicable Date could be date of marriage, divorce, birthday, etc.

Section C

Multiple Group Coverage

Complete if you, your spouse or dependents are covered by any other health or dental plan, sponsored by an employer or by Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	EFFECTIVE DATE (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDENTS COVERED BY PLAN (Only First Name is Needed)
				☐ Health ☐ Dental	☐ Employee ☐ Retired	☐ A ☐ A&B	
				☐ Health ☐ Dental	☐ Employee ☐ Retired	☐ A ☐ A&B	
				☐ Health ☐ Dental	☐ Employee ☐ Retired	☐ A ☐ A&B	

Section D

Explanations

Section E

Employee Agreement and Signature

Before signing, make sure all applicable sections are complete so your enrollment is not delayed. You may be asked to provide additional information and or documentation. Please note: It is the employee's responsibility to notify the Public Employees Health/Dental Program ***within 60 days of any change*** *affecting dependent eligibility (i.e., birth, marriage, divorce, etc.).*

I represent that all information is true and correct. I understand and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRC Section 125 Flexible Benefits; (2) authorize PEHP/PEDP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the Health Plan; (3) certify all dependents listed are eligible for coverage; (4) understand if PEHP/PEDP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP/PEDP for any claims paid in error; (5) agree to the terms and conditions in the PEHP/PEDP Master Policy.

EMPLOYEE SIGNATURE	DATE

Please make a copy for your records.